# A Family Systems Nursing Interview Following a Myocardial Infarction: The Power of Commendations

**Ursula Bohn, R.N., M.N.**
**Lorraine M. Wright, R.N., Ph.D.**
**Nancy J. Moules, R.N., Ph.D.**
*University of Calgary*

*The onset of life-threatening or chronic illness irrevocably changes the trajectory of the lives of individuals and their families. The beliefs held about the illness may affect the way individuals and family members cope with the illness as well as the illness itself. The illness beliefs model proposes that a therapeutic conversation that includes the identification of, assessment of, and intervention with constraining beliefs about illness may have a powerful and sustaining influence on individuals' and family members' ability to integrate illness into their lives. The authors present a therapeutic conversation that occurred during two sessions in the Family Nursing Unit at the University of Calgary, with a woman experiencing "feeling overwhelmed and stressed" 6 weeks following the diagnosis of a myocardial infarction. Highlighted is one family nursing intervention, commendations, which shows promise in challenging constraining beliefs that may diminish the perception of strengths and increase suffering.*

*Keywords: family systems; commendations; myocardial infarction; nursing*

A new diagnosis of myocardial infarction can be a life-altering event. Symptoms are experienced physically, emotionally, and spiritually as well as individually and between family members. The health care team has become expert at addressing physical symptoms with state-of-the-art interventions. A multidisciplinary focus is directed at teaching the prevention of future heart attacks. Fiscal constraints and early discharge, however, may have combined to allow minimal focus on emotional and spiritual suffering.

Linda[1] was a 53-year-old woman who was seen once individually and once with her husband, Bill, at the Family Nursing Unit (FNU) at the University of Calgary. Linda described her presenting problem as "feeling overwhelmed and stressed since experiencing a myocardial infarction 6 weeks ago." Linda reported significant improvement after the first session, "53%—or even 54%—improvement." Linda's improvement continued until her second session 3 weeks later, at which time she reported "feeling back to normal" and described accomplishing behavioral goals she had set for herself.

This article will describe a therapeutic conversation within the context of Wright, Watson, and Bell's (1996) illness beliefs model that evolved with Linda in the first session and carried on with Linda and her husband in the second session. Special emphasis will be placed on one specific family nursing intervention, commendations. This case study may have implications for nursing practice with a population of patients and families with a new diagnosis of cardiac disease not only in terms of alleviating emotional and spiritual suffering but also potentially in preventing further heart disease.

## THE FNU

The FNU at the University of Calgary was established in 1982 under the direction of Dr. Lorraine M. Wright. The FNU offers assistance to families when one or more members are experiencing difficulties with health problems such as chronic illness, life-threatening illness, or psychosocial problems. Referrals can be made by families or by health care professionals.

This unique unit integrates clinical practice, education, and research. Clinical work with families occurs in the context of a "clinical nursing team approach" (Wright et al., 1996). The team consists of faculty members, graduate nursing students at the master's or doctoral levels, and occasionally, visiting graduate nursing students or faculty from other countries. In the work with this family, a visiting professor from Japan was part of the clinical team and provided the team with her own unique perspective. The team observed through a one-way mirror while one team member, the clinician (a graduate student or faculty), interviewed the family. The author, a second-year master's of nursing student, was the clinician for these sessions under the supervision of Dr. Lorraine M. Wright and Dr. Nancy Moules. The entire work is a team endeavor; the team participates in the therapeutic conversation through the use of telephone calls to the clinician and the reflecting team as well as through postsession discussion (Wright, Watson, & Bell, 1990,1996).

## THE ILLNESS BELIEFS MODEL

The illness beliefs model is the framework for advanced clinical practice in the FNU. This model is based on theoretical underpinnings of cybernetics, systems theory, communication theory, and narrative theory. Perhaps most influential has been the worldview of Chilean neurobiologists Maturana and Varela (1992): the postmodern belief that the world is a world brought forth with others in language. Maturana and Varela proposed that individuals are structurally determined; each individual's biopsychosocial-spiritual structure is unique and a product of his or her phylogeny and ontogeny. An individual's present structure determines which interactions will give

rise to change. Maturana and Varela further offered that individuals are part of living systems that are constantly changing through interactions with each other, through structural coupling. These notions of structural determinism and structural coupling have given rise to the unique stance of the illness beliefs model. Clinician/family relationships are respectful, compassionate, and nonheirarchical. Clinicians do not change families; interventions are offered to families. The illness narrative is valued; families are considered experts about their experiences. Families are viewed through a lens that seeks out and celebrates family strengths.

Wright et al. (1996) believe that the illness of one family member affects the whole family and that reciprocally, the family can affect the illness. They proposed that the suffering family members experience in illness is often related more to their beliefs about the illness than to the illness itself. These beliefs include beliefs about diagnosis; beliefs about etiology; beliefs about healing and treatment; beliefs about mastery, control, and influence; beliefs about prognosis; beliefs about religion and spirituality; and beliefs about the role of illness in our lives. Beliefs can either be constraining or facilitating. Constraining beliefs may contribute to suffering and may restrict options for change and problem resolution, whereas facilitating beliefs may give rise to options for solutions and change.

## COMMENDATIONS: A MICROMOVE

The offering of commendations is a central micromove that defines the beliefs and the practice of the FNU. Commendations may be viewed as a stance or as way of being in relationship with another. A commendation may be inherent in attentive listening and in the validation of suffering. A commendation may attest that the illness narrative has, indeed, been heard. Wright et al. (1996) believe that commendations increase structural coupling between family members and the clinician. "They are, in essence, conversations of affirmation and affection between the clinician or clinical team and the family and thereby open possibilities for healing" (Wright et al., 1996, p.178).

Wright et al. (1996) chose the word *commendation* to "name the clinical move in which the clinician draws forth and highlights family strength's" (p. 177). Commendations are offered to every family in every therapeutic conversation. Clinicians are invited and encouraged to offer families a commendation early in each session. Such commendations may applaud families' efforts and initiative in seeking help, a view that may be in contrast with families' sense of failure or their perception that "things must be very bad if they need help." Even in a 15-minute interview, Wright and Leahey (1999) endorsed the offering of at least two commendations to family members about individual or family strengths.

Commendations are distinguished from compliments. Commendations are observations of patterns of behavior that occur across time (Wright & Leahey, 2000). Content elements of commendations include using language that supports families' worldviews, relating the commendation to families' beliefs, and relating commendations to families' progress or solutions (McElheran & Harper-Jacques, 1994).

The delivery of a commendation should capture family members' attention. The clinician may stop the interaction with, "I just need to say how impressed I am with..." Commendations by members of the clinical team other than the clinician may have a powerful impact on families. The team may phone the clinician from behind the one-way mirror to offer a commendation. If a reflecting team is offered to a family, each team member offers a commendation that may be a validation of the family's illness story or an observation of an individual or family strength. Commendations may be further ritualized in therapeutic letters that are offered to families from the clinical team after individual sessions and after the closing session.

## THE FIRST SESSION

### The Presession

Each session in the FNU begins with the student clinician assigned to the family presenting a presession to the clinical team. A literature review and selection of articles that may be useful to the family is part of the structure of each presession. Hypothesizing about possibilities of the family's experience is based on the articles and on reflections about the family.

In this presession, one article chosen for Linda, a 53-year-old woman who had experienced a myocardial infarction, was Tobin's (2000) "Getting back to Normal: Women's Recovery After a Myocardial Infarction." A belief hypothesis (Wright et al., 1996) based on this article was that in the 6 weeks after myocardial infarction, Linda might be struggling to accept the reality of the heart attack. She may wonder what it was that caused her to have a heart attack. The heart attack might have challenged a belief that being so much younger than her spouse, she would not be the one to become ill or die first. She may be having ongoing chest pain, reminding her of her illness and making her worry. Linda's worrying may be adding to her chest pain.

The second article chosen was Tapp's (1993) "Family Protectiveness: A Response to Ischemic Heart Disease." Linda, at 53, was significantly younger than her husband, Bill, age 65. Linda's children were 34, 32, and 23. A belief hypothesis based on this article was that the family might not be responding to Linda with "family protectiveness." They may not be assuming more responsibilities for household maintenance. They may be unaware of any need to do so as it was

"only a mild heart attack." Linda may feel physically unwell but may continue to assume most of the household responsibility. She may believe it is her role to look after the house and family. Some of Linda's stress and anxiety may be related to a sense of dissonance between what she feels she should do and what she feels able to do.

Hypotheses are not regarded as "truth" but as direction for the interview. Questions are developed to either validate or discard the hypotheses (Wright et al., 1996).

**Preparing the Ground**

At the start of the session, in a deliberate attempt to create a collaborative relationship between the clinician and the family member, the clinician personally greeted Linda and escorted her to the interview room. The clinician introduced herself and the faculty and student team members behind the mirror. Linda was offered the opportunity to meet the team. Although prior to the session, Linda had been prepared about the interview format, the clinician explained the purpose of the telephone and the one-way mirrors and obtained consent for videotape recording. The clinician discussed the format of the session and the usual contract for four sessions. Wright et al. (1996) offered that "the provision of structure seems to reduce the unknown, making people who are strangers feel more comfortable, and is a first, concrete step in preparing the ground" (p. 132).

The following is dialogue from the first minutes of the session.

*Linda:* I'm not sure I should even be here with everything that happened last week [terrorist activities in the United States].

*Clinician:* We have all been affected by what happened last week. I suspect, though, that whatever your concerns are, that they are just as valid today as they were before last week.

*Linda:* I had a heart attack August 1st. Now, 6 weeks later, I'm at a roadblock, not getting anywhere. I'm not the person I should be despite good things happening in my life, like marriages and grandchildren. I've had no help from anyone. I myself took all the initiative. I called the [FNU] and the Cardiac Wellness Center.

*Clinician:* In spite of feeling so low, you were able to take the initiative to seek out help! I just need to stop and say how impressed I am that you were able to seek out help like that. Many people wouldn't have been able to do that.

Two commendations took place in this early piece of dialogue. The first commendation validated Linda's value as a person, suggesting that despite global issues that surround us, her concerns were important to her and to the clinical team. She was right to seek help. The second commendation focused on Linda's wisdom in knowing when and then choosing to get help. According to Wright et al. (1996), families often perceive their decision to get help as a low point in their lives. This commendation offers an alternate view of Linda as capable and insightful rather than as incompetent and failing.

One useful tool in preparing the ground during the first session is the genogram "to begin a purposeful therapeutic conversation and elicit information about the family's experience in a non-threatening manner" (Wright et al., 1996, p. 132). An examination of Linda's genogram elicited multiple issues of illness, death, and loss in the family. Linda's parents had died as had two previous husbands. Linda was separated from her two eldest children for 10 years. Linda described physical, sexual, and alcohol abuse within her family. According to Linda, she had seen a psychiatrist in the past and had been diagnosed as being bipolar. The following conversation ensued about Linda's belief about her diagnosis of bipolar.

*Clinician:* Do you believe this diagnosis?

*Linda:* No, I see myself as deep and sensitive, passionate to other people's feelings.

*Clinician:* So, I'll write that, "deep, sensitive, passionate to other's feelings."

The clinician then wrote down specifically what the client has said. This "audible note taking" (Wright et al., 1996) indicated to the client that her words have been heard, noticed, witnessed, and documented, an act that can be empowering and validating to a woman who has had her own voice silenced. This response by the clinician also inherently commends Linda for her stance as "expert" about herself, for privileging her own voice over the voice of the psychiatrist. Believing oneself deep, sensitive, and passionate about the feelings of others is a facilitating belief that may invite more options for healing.

The construction of the genogram brought forth not only the story of Linda's past suffering and loss but also the story of the love and affection Linda experiences in her life today. Linda described her husband Bill as "a rock, my salvation, he has taken LIS all on and all our baggage." She spoke about her children and their upcoming marriages and impending births, using the language "wonderful" son and "beautiful" daughter. Throughout the conversation that elicited the genogram, the clinician validated and acknowledged Linda's suffering. The following commendation focuses on Linda's strength in overcoming adversity.

*Clinician:* I just need to stop and acknowledge some of the things you've not only been through and suffered but also been through and survived!

**Distinguishing the Problem**

Through their clinical experience with families, Wright et al. (1996) have come to believe that "the experience of suffering becomes transposed to one of spirituality as families try to make meaning out of their suffering and distress" (p. 170). The following dialogue ensued from the clinician's invitation to Linda to speak about her spirituality.

*Linda:* If I had another [myocardial infarction] and I was to die, I would be ready, spiritually ready, to move on. I am a spiritual person, I want to go to church, but I don't feel good enough. 1 start to get ready, then I feel I don't have the proper clothes or the proper grammar.
*Clinician:* Are there any practices that you do find helpful?
*Linda:* I talk to the Lord.
*Clinician:* You talk to the Lord. What do you talk about?
*Linda:* I don't blame the Lord, but I ask, "Where do I go from here?"

The clinician's use of Linda's own language helps create the bond that Maturana and Varela (1992) described as structural coupling. The clinician again delved for Linda's strengths and for her own solutions for dealing with her suffering.

Upon completion of the genogram, the clinician asked Linda what she most wanted to speak about: issues of the past, the story of the myocardial infarction, Linda's coping now, or some totally different problem. This question again acknowledges that Linda is the expert in regards to her life, her issues, and her illness story. As expert, Linda is invited to designate the focus of the clinical sessions. Linda identified that she most wanted to work on her current issues of coping with her coronary.

> That's all in the past. I feel like a flea, an elephant is crushing me. I haven't risen since the heart attack. I need to be able to be strong again, to be the woman I used to be. Before the heart attack, I was walking arid working, talkative and humorous.

**The Reflecting Team**

In the latter part of each session in the FNU, family members are asked whether they would like an opportunity to hear the team's thoughts and ideas. The family is invited to view the team from behind a one-way mirror. The team offers observations, commendations, wonderings, and questions. Based on beliefs about structural determinism (Maturana & Varela, 1992), it is unknown which thoughts or ideas will trigger a reflection for a family, a reflection that may open space for more facilitating beliefs.

The following is a summary of the thoughts of the reflecting team for this session with Linda.

*Member 1:* I want to commend Linda for seeking help and to validate her for all she has experienced. And she is still forging ahead!
*Member 2:* Such loving descriptions of her husband and children, "wonderful husband", "beautiful daughter." With all Linda has experienced, it would have been easy to be bitter.
*Member* 3: The heart attack robbed Linda of so many things, her confidence, her comfort in church. We shouldn't let it get away with that!
*Member 2:* Anyone that young, 53 years of age, would have their confidence knocked by an [myocardial infarction].
*Member* 1: I wonder if how Linda is feeling may be fairly typical; low-grade depression may be fairly typical 6 to 8 weeks following a heart attack. It may even be due to chemical changes.
*Member 4:* I wonder if Bill wouldn't be willing to help with some of the things that Linda finds so overwhelming right now.

In reviewing the experience of listening to the reflecting team, the clinician inquired, "What was that experience like for you? What stood out from their comments?" This question invited Linda to reflect on which comments were a "fit" for her.

Linda responded with a much lighter affect; she might even be described as glowing. Her comments stood out against her previous description of herself as being so oppressed physically, psychologically, and spiritually by the myocardial infarction. "Beautiful women see me as a beautiful person! I will call [employment insurance and the Wellness Center] this afternoon. If I'm not satisfied, I will go higher... I feel good!"

The team responded to Linda's response by phoning with one further observation: "We wonder if today's session may have raised Linda's self-esteem."

*Linda:* I think my self-esteem is up by 50%.
*Clinical team:* Wow! It seems like Linda's self-esteem may be up even a tiny bit more, maybe 53% or 54%!

We believe this dramatic and quick change in this woman was due to the offering of

commendations by both the clinician and the clinical team in the context of a therapeutic conversation that listened to and validated Linda's illness story.

## THE SECOND SESSION

### Therapeutic Letters

A part of the clinical practice in the FNU is the writing and sending of a letter following each session. In the letter sent to Linda, the clinician again acknowledged the suffering experienced by Linda and highlighted the commendations offered by the team so that the feelings of affirmation that Linda had experience could be extended and reinforced. The team also invited Linda to bring her husband, Bill, to the next session.

### The Second Presession

The clinician chose Hilbert's (1996) "Cardiac Couples at Hospitalization and 3 Months Later." Hilbert suggested that spouses may have even more negative affect than does the person who experienced the myocardial infarction. A belief hypothesis based on this article and on information from the first session was that Linda may be unaware that Bill is suffering as well. She had described Bill as a rock, stating his only health concern was "looking after her." She may believe because Bill seems strong that he is not suffering. Bill may not share his suffering with Linda, believing mat men hold their feelings inside.

The second article chosen was Rolland's (1994) "In Sickness and in Health: The Impact of Illness on Couples' Relationships." According to Rolland, illness can either increase a couples' intimacy or make them more distant. A hypothesis developed from this article and from information from the first session was that Linda may believe that "getting back to normal" is important to Bill and to their relationship. She may believe that she and her previous problems have been a burden to him. Despite an underlying belief that she could die from another myocardial infarction, Linda may refrain from sharing her concerns about her health with him. Bill may worry about Linda having another heart attack and the possibility that he might lose her, but he may believe that to say this out loud might cause Linda to become even more stressed and may even precipitate another heart attack.

### What Stood Out

An intervention in subsequent sessions, based on the belief in structural determinism, is that the clinician inquires of family members what stood out for them from the previous session and from the therapeutic letter. This inquiry acknowledges that an intervention must be a "fit" with an individual's biopsychosocial-spiritual structure before it is taken up. Linda spoke about a significant improvement in her mood and in her self-esteem. "I felt like a fly, now that's reversed, now I'm the big guy." Linda believed this improvement to be related to the positive comments made by the clinical team and reiterated in the letter, stating, "One can only believe that one is as good as one is perceived to be." Linda reported that after the last session, she felt her "confidence was so high, I could take on the world." She had made the phone calls she had been dreading and as a result, was accepted into the cardiac wellness program. Other successes included attending and enjoying the wedding of her daughter and becoming a grandmother again.

### The Marital Relationship

Illness, especially a myocardial infarction, has an impact on the marital relationship. The clinician asked Linda and Bill how their relationship had changed since the heart attack.

*Bill:* I worry more about her. With her family history, I worry that she'll have another one and be gone.
*Clinician:* [After clinical team phone in.] Does Bill believe that the heart attack was more related to lifestyle or to genetics? Does Linda worry about Bill?
*Bill:* I think Linda has some control over her health risks by exercising and following a diet.
*Linda:* It's always been me who has been sick. If I were to lose him, the loss would be great. I'd never find anyone like him in terms of love, respect, compassion, and care.

Conversation ensued about how Bill encourages Linda, how he does the shopping and has tried to make better food choices for both of them, and how he invites her to walk with him.

The clinician offered a commendation to the couple about their openness, their ability to speak to each other about difficult subjects, and about their support of each other. The faculty supervisor phoned the clinician to relay the team's impression to Linda and Bill that they were also impressed with Linda and Bill as a couple.

Bill responded to this commendation by acknowledging the support he receives from Linda. He offered an example of a time when he was laid off from his job and anticipated that Linda would be

unhappy or perhaps would even blame him. In fact, Linda responded to the news of his unemployment by expressing warmth and support, saying it was time he retired. The clinician commended Bill on being able to give so specific an example of something about Linda that he appreciates.

### The Reflecting Team

In the latter part of this session, the couple was again asked whether they would like an opportunity to hear the team's thoughts and ideas. Linda and Bill were invited to view the team from behind a one-way mirror.

*Member 1:* They are an impressive couple. They have the potential to teach other couples; they are an inspiration in terms of love and caring.
*Member 2:* Bill seems like a "renaissance man," atypical for men of his generation, so open with his feelings.
*Member 3:* I have to commend Linda. After her previous relationships that were painful, it would have been easy to be bitter rather than loving and open.
*Member 4:* According to research findings, after [an myocardial infarction], the emotional support of the most important person in your life is healing and preventative, as important as lifestyle in preventing another [myocardial infarction].
*Member* 1: Their personality differences are a wonderful complement to each other. Bill is goal oriented, Linda ponders things.
*Member 4:* Linda's feelings may well have a chemical component, and if the low feelings return, she could either return to the FNU or be checked out medically. She may also experience improvement in her emotional as well as her physical health at the Cardiac Wellness Center.

### Response to the Interview

Linda and Bill stated that this would be their last session. They found the sessions most valuable, stating they felt valued and understood. As the most helpful aspect of the sessions, they identified the "positive comments" from the clinician and the clinical team.

## IMPLICATIONS FOR NURSING PRACTICE

Illness affects the whole person and the whole family. Inviting families into therapeutic conversations creates a context for challenging constraining beliefs that contribute to suffering. Encouraging family members to tell their own stories and focusing on family strengths rather than deficits may have profound implications for promoting health. Individuals may, like Linda, feel improvement in their affect by embracing more facilitating beliefs about themselves.

One can only assume that Linda is not alone in her experience of "feeling overwhelmed and stressed " in the weeks and months following the diagnosis of a myocardial infarction. The author suggests that ail individuals and families be offered an opportunity to have a therapeutic conversation upon receiving a life-altering diagnosis. Based on the belief that illness affects families and families affect illness, there may be a preventative aspect to therapeutic conversations; there may be the potential for therapeutic conversations to improve physical, emotional, and spiritual well-being in the individual diagnosed with the illness as well as in other members of the family.

## CONCLUSION

In this article, the author presented a family systems nursing interview that took place with a 53-year-old woman, Linda, recently diagnosed with a myocardial infarction, in the FNU at the University of Calgary. This therapeutic conversation brought forth Linda's experience of physical, emotional, and spiritual suffering. The invitation to speak about the impact of the illness on her life in the context of the illness beliefs model (Wright et al., 1996) seemed to significantly alleviate Linda's suffering.

One intervention within this model is the offering of commendations, conversations of affirmation and affection between the clinician or clinical team and families that may open possibilities for healing. By commending families' competence and strength and offering them a new opinion of themselves, a context for change may be created that allows families to discover their own solutions to problems. Commendations allow families to celebrate their own courage, wisdom, and success. Linda identified the "positive comments" from the clinician and the team as the most helpful aspect of the sessions.

Inviting families to a therapeutic conversation and focusing on family strengths through the use of commendations may be an important part of the care of all individuals and their family members who have received a life-altering diagnosis. The benefits may be the alleviation of present physical, emotional, and spiritual suffering. Also, there may be the potential benefit of preventing further disease and health promotion for all family members.

## NOTE

1. Names were changed to protect confidentiality.

## REFERENCES


Hilbert, G. A. (1996). Cardiac couples at hospitalization and 3 months later. *Journal of Family Nursing, 2,* 76-91.

Maturana, H. R., & Varela, F. (1992). *The tree of knowledge: The biological roots of human understanding* (Rev. ed.). Boston: Shambhala.

McElheran, N. G., & Harper-Jacques, S. R. (1994). Commendations: A resource intervention for clinical practice. *Clinical Nurse Specialist, 8,* 7-15.

Rolland, J. (1994). In sickness and in health: The impact of illness on couples' relationships, *journal of Marital and Family Therapy, 20,*327-347.

Tapp, D. M. (1993). Family protectiveness: A response to ischemic heart disease. *Canadian Journal of Cardiovascular Nursing,* 4(2), 4-8.

Tobin, B. (2000). Getting back to normal: Women's recovery after a myocardial infarction. *Canadian Journal of Cardiovascular Nursing,* 31(2), 11 -19.

Wright, L. M., & Leahey, M. (1999). Maximizing time, minimizing suffering: The 15-minute (or less) family interview. *Journal of Family Nursing, 5,*259-274.

Wright, L. M., & Leahey, M. (2000). *Nurses and families: A guide to family assessment and intervention* (3rd ed.). Philadelphia: F.A. Davis.

Wright, L. M., Watson, W. L., & Bell J. M. (1990). The family nursing unit: A unique integration of research, education, and clinical practice. In J. M. Bell, W. L. Watson, & L. M. Wright, *The cutting edge of family nursing.* Calgary, Alberta, Canada: Family Nursing Unit Publications.

Wright, L. M., Watson, W. L., & Bell, J. M. (1996). *Beliefs: The heart of healing in families and illness.* New York: Basic Books.